

**Institutional Review Board**  
North Dakota Department of Human Services  
**Research Progress Report**

Type all answers

**\*NOT TO BE USED TO CHANGE PRINCIPAL INVESTIGATOR**

☐ Continuing Review      ☐ Final Report

Local Sites to be Notified: (Circle):    WCHSC    LRHSC    BHSC    SEHSC    NEHSC    State Hospital  
   NCHSC    NWHSC    SCHSC    NDDC    Other:

**1. General Information**

Principal Investigator: \_\_\_\_\_ ☐ DHS    ☐ Non-DHS  
Address: \_\_\_\_\_  
Dept./College: \_\_\_\_\_ Box No. \_\_\_\_\_ Tel./Fax #: \_\_\_\_\_  
Co-Investigator(s): \_\_\_\_\_  
\_\_\_\_\_

**2. Protocol Information**

Title of Project: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Sponsor/Grant agency: \_\_\_\_\_ Protocol No./Identifier \_\_\_\_\_

**3. Continuing/Final Report Information**

No. of participants initiated since last review: \_\_\_\_\_ Total no. initiated into this project: \_\_\_\_\_  
Are you continuing to recruit new participants? ☐ Yes    ☐ No    If yes, attach most current informed consent(s).

How many recruited participants have withdrawn/dropped? \_\_\_\_\_ Explain why?: (Tab to indented next line)

**Summarize the research hypothesis or purpose of this project and procedures:** (Tab to indented next line)

**Summarize ALL of the data derived in this project from inception to date and/or attach abstracts, reprints, progress reports, pertinent to this study.** (Tab to indented next line)

**Were benefits of this research expected? Were they realized? Explain.** (Tab to indented next line)

**Does the present data justify continuation of the study? Explain.** *(Tab to indented next line)*

**Does the risk/benefit ratio justify continuation of the study? Explain.** *(Tab to indented next line)*

**At this time, are you revising the Informed Consent to include any significant new findings which may relate to the participants' willingness to continue participation?**

☐ **Yes** ☐ **No** If yes, please attach a copy of the revised consent form and **highlight** all revisions.

**Final Report:**

I am terminating this study for the following reason:

"I confirm the accuracy of the information stated in this report."

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**Signature of Principal Investigator**

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**Date**

Please return this application and any attachments to:

Mental Health and Substance Abuse Services  
Attn: DHS IRB Chair  
1237 West Divide Ave, STE. 1C  
Bismarck, ND 58501-1208

**Affiliate institution as indicated on the first page.**

## Continual Review

IRB Proposal # \_\_\_\_\_

### FOR IRB USE ONLY:

\_\_\_\_\_ Full Board Review

\_\_\_\_\_ Exempt

\_\_\_\_\_ Expedited Category #

Expedited Review By:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IRB Chairperson Signature

Date